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HEALTH SERVICES RESTRUCTURING COMMISSION

Rural and Northern Hospital Networks

Network 3
Wellington

March 1999

• Guelph General	Guelph
• Guelph St. Joseph's	Guelph
• Homewood Health Centre	Guelph
• Groves Memorial	Fergus
• Louise Marshall	Mount Forest
• Palmerston & District	Palmerston

This differs from the Network Members identified by HSRC in July 1998. At that time the following were noted as members of Network #3:

- Guelph General
- Groves Memorial, Fergus
- Louise Marshall, Mount Forest

The structure of this report is as follows:

Section A — **Introduction and Background**
Identifies the special issues related to the provision of health care in rural and northern communities and the HSRC principles for restructuring in these communities.

Section B — **Community Overview and Report on Progress to Date**
Provides an overview of the community and the progress made to date in restructuring health services.

Section C — **HSRC Approach to Restructuring in Rural and Northern Communities**
Describes the process for network formation and the responses received from the community regarding the proposed networks.

Section D — **Network Goals, Objectives and Tasks (Terms of Reference)**
Provides an overview of the goals and objectives of the network participants. The tasks required to meet these goals and objectives and options to facilitate decision making are included.

Section E — **HSRC Conclusions**

Appendices:

1. **Network Map**
2. **List of Rural and Northern Networks**
3. **Excerpts from *Examples of Excellence in Primary Care*, Ontario College of Family Physicians**
4. **Organization Models and Definitions**
5. **Network Plan Report Template**

Section A: Introduction and Background

HSRC Mandate and Terms of Reference

The HSRC, established in the spring of 1996, is an independent body operating at arm's-length from the government. The Commission's four-year mandate consists of three specific and closely related components:

- To make binding decisions to restructure Ontario's public hospitals;
- To provide advice to the Minister of Health about which health services will require reinvestment as a result of changes to the hospital system and changing needs of the population; and
- To make recommendations to the Minister on restructuring other components of the health care system leading to creation of a genuine, integrated health services system.

During the first two and a half years, the HSRC concentrated its attention on three primary objectives:

1. The creation of a working hypothesis – a vision of the health services system describing what Ontario needs to meet the challenges of the early 21st century.[1]
2. Restructuring hospitals in larger, primarily urban, communities.
3. The establishment of planning guidelines to support recommendations made to the Minister of Health on reinvestments required to support restructuring of acute care facilities namely, home care, long term care, rehabilitation, mental health, and sub-acute care.[2]

Rural and Northern Hospital Review

In June 1998, the HSRC began the phase of its work related to restructuring hospitals in rural and northern parts of the province. The HSRC's overall goal for restructuring hospitals in rural and northern communities remains the same as for urban communities: to ensure that each of the networks will provide optimum accessibility to the highest possible

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1 *A Vision of Ontario's Health Services System*. Health Services Restructuring Commission, Toronto. January 1997. The vision included a description of the desirable characteristics and overall structure of Ontario's health services system. The vision document was released as a working hypothesis and is being used by the HSRC as the basis for further developing a policy framework and for making recommendations to the Minister of Health on the steps and strategies required to proceed from vision to actual system-building.

2 *Change and Transition: Planning Guidelines and Implementation Strategies for Home Care, Long term Care, Mental Health, Rehabilitation, and Sub-acute Care*. 1998. Health Services Restructuring Commission.

quality of hospital based services for the population served in the most cost-effective way. However, from the beginning of its mandate, the HSRC acknowledged there are particular challenges and conditions in rural and northern communities. The HSRC recognized that the methods and procedures developed for restructuring in urban areas would not be suitable for rural and northern hospitals.

The HSRC's approach to restructuring rural and northern hospitals builds on its understanding of rural and northern issues as well as the policy guidelines established by the Ministry of Health in *The Rural and Northern Health Care Framework* [3].

The HSRC developed a number of underlying assumptions at the outset of its review of rural/northern communities. These include the following:

- *Ontario's rural and northern hospitals should be networked, or formally linked with one another. Member hospitals in each network will collaborate and provide one another with mutual support and enable the coordination of services at the planning, operational and strategic level.*
- *Each network is to contain a secondary care, referral hospital (referred to as 'C' hospitals in the MoH Rural and Northern Health Care Framework.)*
- *The primary goal of the HSRC's approach to rural and northern hospitals is to ensure that each of the networks will provide optimum accessibility to the highest possible quality of hospital-based services in the most cost-effective manner for the population in all communities served by the member hospitals.*
- *Hospital closures in rural and northern communities are neither desirable nor feasible. However, there are savings that can be derived through clinical and administrative efficiencies that can be redirected to the maintenance and, where possible, enhancement of patient care programs and services.*

The HSRC is approaching the creation of hospital networks in rural/northern Ontario through a two stage process:

Stage 1

- Confirm network membership
- Formalize linkage(s) between rural hospitals [within each network] and their major secondary referral hospital.
- Articulate tasks to be achieved by the networks as part of stage 2 activities

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[3] Ministry of Health [1997]. The *Rural and Northern Health Care Framework* uses the term regional to describe a system of "networks" or clusters" called Rural and Northern Health Care Networks. It is through these networks that hospitals will be formally linked. As stated in the framework hospitals within about 40 kilometres of each other will be expected to form clusters (networks) with shared administrative, support and clinical functions as well as explore opportunities for common governance. If a hospital cluster is more than about 40 kilometres away from a full service emergency hospital, at least one of the hospitals within the network will have enough secondary resources to provide Level B emergency services with the remainder providing Level A access, triage and transportation.

Stage 2

- Networked hospitals will work together to carry out the objectives and terms of reference/ tasks set by the HSRC. Implementation plans and progress reports are to be submitted to the HSRC no later than September 20, 1999.

Characteristics of Rural and Northern Hospitals

The HSRC's analysis of rural and northern hospitals revealed common characteristics. These characteristics point to the need for an approach to restructuring in rural and northern hospitals that is tailored to these hospitals.

Role of Rural and Northern Hospitals

Hospitals in rural and northern areas play an essential role in the provision of health care to residents in these communities. Rural and northern hospitals often provide the only access to acute care, emergency services and specialty services in the community. They may be the only source of diagnosis and after-hours health care. Because many provide supervised care on a 24 hour basis, they often provide primary health care services as well as performing an important social services role normally provided by a variety of other organizations in urban communities. As a result, residents in rural and northern areas maintain a particularly strong identification with, and loyalty to, their local hospital. The HSRC recognizes the importance of rural and northern hospitals in the provision of health care in these communities. It is anticipated that the formation of networks, whose members will plan for the health care needs of the region as a whole, will facilitate access to high quality primary and secondary services.

Access to Services

Ensuring access to health services in rural and northern communities presents particular challenges. The low population density common to many of these communities, means that the variety of services that are available in urban areas are found only in regional centres located distant to local communities. Many rural areas lack public transportation systems which creates challenges concerning access to health care services. Ensuring access to services such as emergency health care, obstetrics, surgery, and mental health, and regional programs provided at tertiary or secondary referral centres is an issue of on-going concern in these communities. Access to follow-up services is also a problem. Distances can restrict the availability of follow-up services in the home and/or the ability of the patient to return to the providing institution for follow-up care.

Low Patient Volumes

The low population density characteristic of many rural and northern communities contributes to low patient volumes for hospitals and other health care providers, making the provision of quality, affordable and accessible care a challenge. Providing services that

achieve a balance between quality and accessibility requires careful planning and collaboration among all health care providers in the region.

In addition the relatively small size of health care organizations in rural and northern communities leads to high fixed operating costs in relation to the overall budget. It is anticipated that networks of hospitals that plan and provide services for a region will enhance the ability of the network members to realize some economies of scale.

Recruitment and Retention of Providers

The shortage of physicians and other health professionals is an on-going challenge in rural and northern areas. The longstanding difficulties in recruiting and retaining sufficient physicians and other health professionals has been well documented in a recent report jointly published by the Society of Rural Physicians of Canada and the Professional Association of Interns and Residents of Ontario. This report, *From Education to Sustainability*[4] outlines some of the historic reasons for the difficulties in recruitment and retention and provides a set of recommendations to address the problem.

Two of the challenges encountered by physicians and other health professionals working in remote parts of the province relate to difficulties in accessing educational resources and limited opportunities to confer with colleagues. Telemedicine and other forms of technologies are opening up possibilities to address these challenges. Innovations such as computerized patient records, decision support systems, community health information networks and other technologies should reduce the sense of isolation of health professionals and can also affect the cost, quality and accessibility of health care.

Conclusion

The development of networks of hospitals that will plan for the needs of the residents of a district, including the location and scope of services required, will provide some solutions to the challenges presented by the particular characteristics of rural and northern communities.

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[4] The Society of Rural Physicians of Canada and the Professional Association of Interns and Residents of Ontario, *From Education to Sustainability: A Blueprint for Addressing Physician Recruitment and Retention in Rural and Remote Ontario*, December 1998.

Section B: Community Overview and Report on Progress to Date

Community Profile

Geographic Boundary and Population

According to the 1996 Census[5], 171,000 people lived in the Wellington County (about 9% increase in population since the 1991 Census). This population represented about 2% of the provincial population.

- Wellington County covers 2,660 square kilometers with a population of 171,395 in 1996. It includes the following communities: Arthur, Clifford, Drayton, Elora, Eramosa, Erin, Fergus, Guelph, Harriston, Maryborough, Minto, Mount Forest, Nichol, Peel, Pilkington, Puslinch, Palmerston, West Garafraxa, West Luther. Table 1 shows the population growth rate between 1991-1996 for each community.

Table 1: Population and Growth Rate in Wellington and Ontario

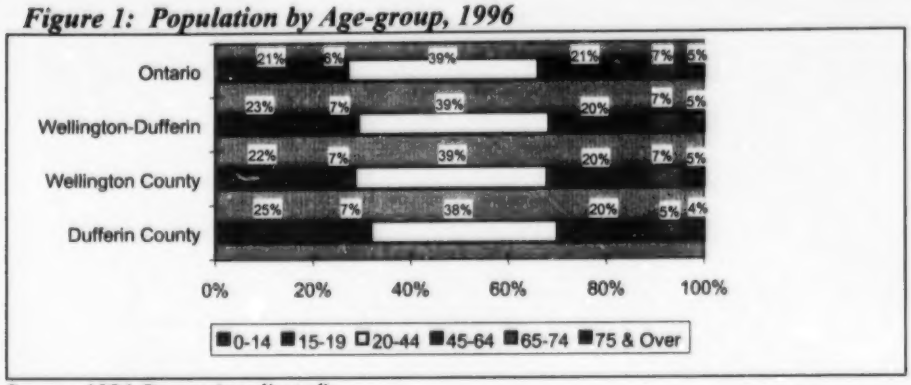
	TYPE	1996 POP	1991 POP	GROWTH RATE	ANNUAL GR
ONTARIO		10,753,573	10,084,885	6.63%	1.33%
WELLINGTON		**171395**	**159609**	**7.38%**	**1.48%**
Puslinch	TP	5416	4943	9.57%	1.91%
Guelph	TP	3282	3274	0.24%	0.05%
Guelph	C	95821	88444	8.34%	1.67%
Eramosa	TP	6317	5949	6.19%	1.24%
Erin	TP	8024	7561	6.12%	1.22%
Erin	VL	2633	2489	5.79%	1.16%
West Garafraxa	TP	3777	3514	7.48%	1.50%
Nichol	TP	4223	3960	6.64%	1.33%
Fergus	T	8884	7940	11.89%	2.38%
Elora	VL	3346	3283	1.92%	0.38%
Pilkington	TP	2577	2415	6.71%	1.34%
Peel	TP	4499	4316	4.24%	0.85%
Maryborough	TP	2882	2729	5.61%	1.12%
Drayton	VL	1427	1201	18.82%	3.76%
Minto	TP	2603	2454	6.07%	1.21%
Clifford	VL	775	784	-1.15%	-0.23%
Harriston	T	2008	1995	0.65%	0.13%
Palmerston	T	2468	2313	6.70%	1.34%
Arthur	TP	2529	2509	0.80%	0.16%
Mount Forest	T	4530	4266	6.19%	1.24%
Arthur	VL	2139	2123	0.75%	0.15%
West Luther	TP	1235	1147	7.67%	1.53%

Source: Statistics Canada, Census 1996 (unadjusted)

5 Statistics Canada recently released 1996 Census population data. These are unadjusted numbers.

Figure 1 shows that the age distribution of Wellington is similar to that of Ontario.

Figure 1: Population by Age-group, 1996

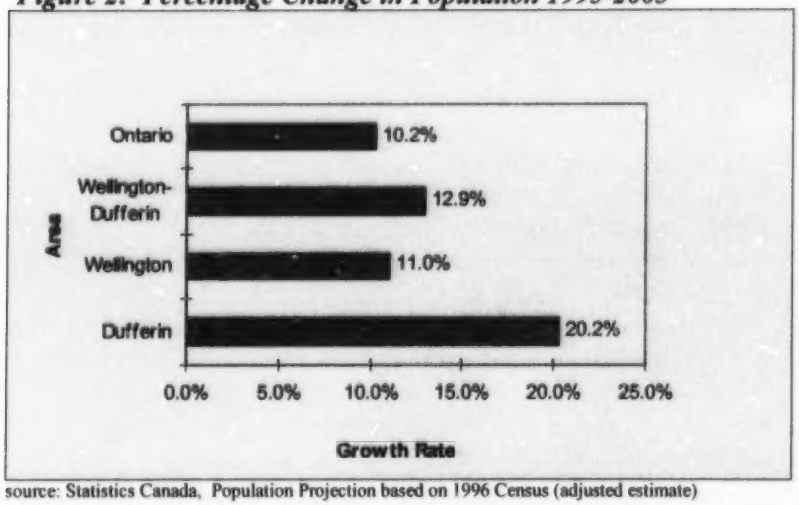


Source: 1996 Census (unadjusted)

Population Projection

A population projection is an estimate of what the future population might be, given alternative plausible assumptions about fertility, mortality and migration. It is difficult to predict population size beyond the most recent census years. The population projection reported below are obtained from Statistics Canada and are based on the 1996 Census (adjusted estimate).

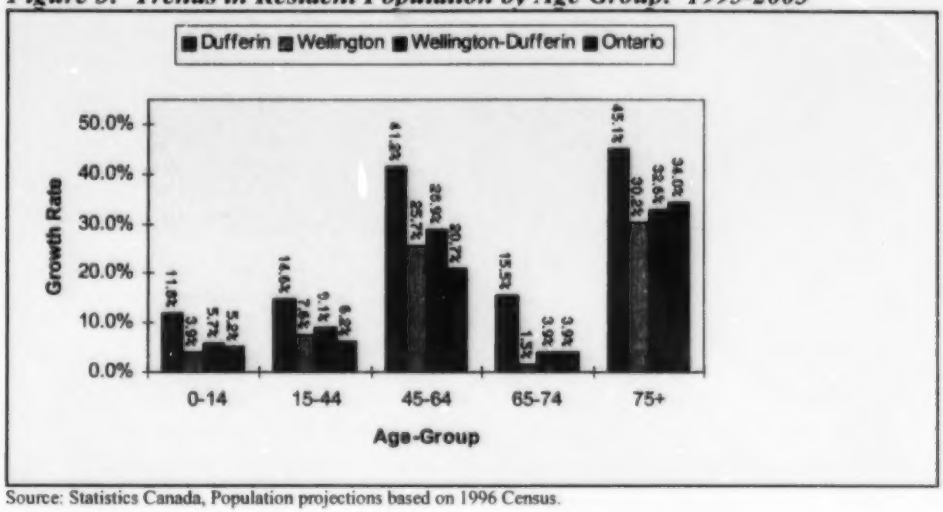
Figure 2: Percentage Change in Population 1995-2003



source: Statistics Canada, Population Projection based on 1996 Census (adjusted estimate)

Between 1995-2003, the population of Wellington is expected to increase by 13%. This is higher than the projected growth for the province as a whole (i.e. 10%). The size of the 0-14 age group is expected to increase by almost 6% in the Wellington County which is close to the provincial rate of growth (i.e. 5%). The size of the 65 and over age group in Wellington is projected to increase at the same rate as the province (i.e. 16%).

Figure 3: Trends in Resident Population by Age Group: 1995-2003



Source: Statistics Canada, Population projections based on 1996 Census.

Socio-Economic Indicators[6]

Socio-economic indicators such as income, education and employment are key determinants of health status as well as health care utilization of a population. The following provides a brief comparison of selected socio-economic indicators between Wellington and the province:

- Wellington reported a lower rate of unemployment than the province as a whole. Unemployment is viewed as a potential risk factor for ill health.

- The proportion of people with low income was lower in Wellington than Ontario. The median household income was higher in Wellington ($45,144) than Ontario ($44,432). Income has been found to have an inverse relation with hospital utilization (i.e. the lower the income the higher the hospital utilization).

- Wellington County had a slightly lower proportion of the population with less than a grade 9 education (10%) than Ontario (12%) and almost the same percentage of university graduates (12.5%) as Ontario (13%). However, Wellington County had a high proportion of university graduates in the area (13.5%). Education is an important determinant of health. Studies have shown a relationship between lower levels of education and the following conditions: unskilled job, high unemployment, and a greater prevalence of disability and health problems .

- Wellington population is less culturally diverse than Ontario (see table 3). According to 1996 Census, the proportion of the population with a mother tongue other than

6 1996 Census data on SES are currently available for only a few variables. This section reports on the data from both the 1991 Census & 1996 Census.

English or French who lived in the Wellington was low (i.e. 12.2%). In addition there was a lower proportion of allophones (people whose home language is neither English nor French) in the Wellington County than Ontario (5.6% vs 12.7%)

- Wellington reported having a lower proportion of single parents than Ontario (11.2% vs 14.4%). Family circumstances (single parent in or out of the labour force) have been found to affect hospital utilization. Studies have shown a relation between lone-parent families and low income. Many problems such as poor housing conditions, overload of parental responsibilities and behavioural problems in children have been associated with lone-parent families.

- The proportion of seniors living alone in the Wellington was the same as Ontario. As seniors grow old, they may require assistance from relatives and friends or other caregivers for their activities of daily living. Some seniors may not have adequate social support and interaction which are important for general well-being, and may require the use of health-related services more than their counterparts.

Table 2: Comparison of Socio-Economic Indicators

Indicators	Source	Wellington	Ontario
Unemployment Rate	1996 Census	6.1%	9.1%
Labour Force Participation Rate	1996 Census	71.2%	66.3%
Education: (% of Pop 15 & over)	1991 Census		
Less than Grade 9 Education		10.6%	11.5%
University (with degree)		13.5%	13.0%
Prevalence of Low Income (% of total pop)	1991 Census	9.3%	13.1%
Median Household Income	1991 Census	$45,144	$ 44,432
Mother Tongue Other than English or French (single response)	1996 Census	13.7%	21.9%
Proportion of Allophones (people whose home language is neither English nor French)	1996 Census	6.7%	12.7%
% of Lone Parent Families	1996 Census	11. 2%	14.4%
% of Seniors (65 +) Living Alone	1996 Census	26.8%	27.3%

Source: Statistics Canada, 1991 & 1996 Census

Health Status Profile

Mortality statistics are commonly used to obtain an overall picture of the most serious diseases that exist in a community. They are useful in assessing and planning health services and programs as well as setting health objectives and assessing achievement.

In 1992, the overall Standardized Mortality Ratio (SMR) was slightly above one in Wellington County. SMR is a ratio of the observed number of deaths in a population under study to the number of deaths that would be expected if it had the same mortality rate as the standard population (i.e. Ontario). Thus, a SMR above 1 means that the Wellington County had a higher mortality rate than Ontario. (Table 3).

Table 3: Wellington County- Standardized Mortality Ratios (1990-1992)

	WELLINGTON	
Year	**SMR**	**Lower & Upper Confidence Level**
1992	1.04	0.98-1.10
1991	1.00	0.94-1.06
1990	0.95	0.90-1.01

In 1992, the number of deaths due to circulatory system (SMR:1.12, CI: 1.03- 1.22), ischemic heart disease (SMR:1.24, CI: 1.1- 1.37) nervous system & sense organ (SMR: 1.61, CI: 1.17-2.05) was significantly higher in Wellington County than Ontario. In 1995, ischemic heart disease was the leading causes of death in the Wellington County followed by cerebrovascular disease.

Table 4 provides the five top leading causes of death in the Wellington County.

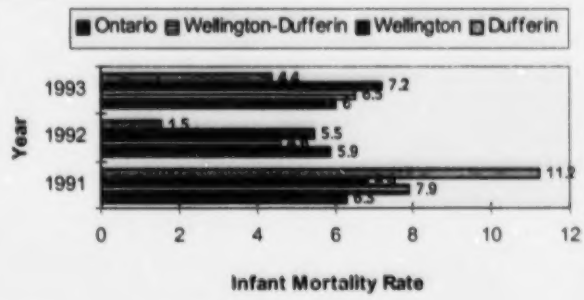
Table 4: Top five Leading Causes of death (Proportional Mortality Ratio PMR) in Wellington county, 1995

Region	1	2	3	4	5
Wellington County	Ischemic Heart Disease	Cerebrovascular Disease	Trachea, Bronchus, Lung	Pneumonia	psychoses

Source: Ministry of Health, HELPS Database

Between 1991-1993, the infant (under one year) mortality rate (IMR- number of infant deaths per 1,000 live births) fluctuated in Wellington County.

Figure 4: Infant Mortality Rate, Wellington-Dufferin & Ontario, 1991-1993



Source: Ministry of Health, HELPS Database

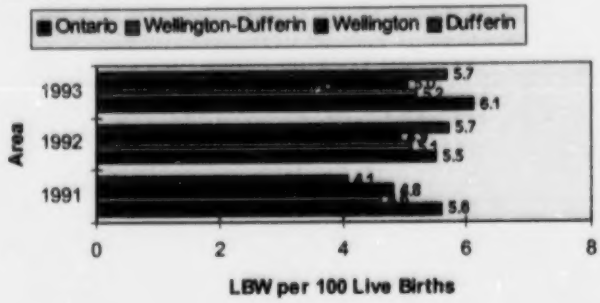
In 1993, Wellington County reported a higher IMR than Ontario and remained similar to Ontario's rate between 1991-1992.

Infant mortality rate is a indicator of the level of social and economic growth of a country. The fluctuation in IMR in Wellington may either be due to poor collection and reporting data (i.e. an artifact) or the result socio-economic circumstances.

Between 1991-1993, the rate of low birth weight babies born to mothers residing in Wellington County has consistently been lower than Ontario (Figure 5).

Infant mortality rate and low birth rate are influenced by such factors as socio-economic conditions or circumstances, maternal age and lifestyle risk factors.

Figure 5: Proportion of Low birth Weight in Wellington-Dufferin & Ontario, 1991-1993



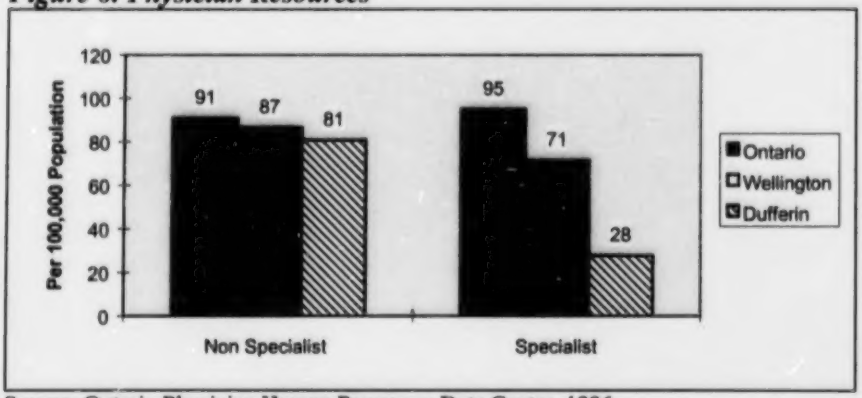
Source: Ministry of Health, HELPS Database

Physician Resources

A review of data from "Physicians in Ontario, 1995"[7] shows lower Specialist and non-specialist physician to population ratios for Wellington County than for Ontario (see Figure 6). Non-Specialist includes: General Practice, Family Medicine, Family Physician/Emergency Medicine.

A lower rate of physicians per 100,000 population should not be interpreted as a risk factor to the health of the community. There can be a variety of reasons for such a difference, including the underlying health of the community (a healthier population may not require as many general physicians), the lifestyle available in the community, health seeking behaviours, etc.

Figure 6: Physician Resources



Source: Ontario Physician Human Resources Data Centre, 1996

7 Ontario Physician Human Resources Data Centre, McMaster University

Progress to Date

Palmerston and District and Louise Marshall (Mt. Forest) Hospitals share a common CEO and administrative functions. Inclusion of Palmerston in the Network respects existing linkages.

The Groves Memorial Hospital in Fergus currently operates under a management contract with the Hamilton Health Sciences Centre (HHSC). The contract stipulates the joint selection and supervision of the site administrator. The benefits to each hospital are significant. Groves Memorial receives administrative and support services from HHSC at lower cost that they were able to achieve on their own. The hospital also benefits from the improved informatics at HHSC. The access to improved information enhances accountability, efficiency and effectiveness in the operations of the hospital. For HHSC, Groves Memorial Hospital represents another site for placement of undergraduate physicians to intern. The community benefits from improved access to physician services at the hospital. The linkage also allows for improved access to services offered by HHSC including transfers for secondary and tertiary services not available at Groves. HHSC also has an opportunity to provide outreach services locally.

The Guelph General Hospital is currently being redeveloped in a two-phase capital project, the first of which is underway. The St. Joseph's Hospital, Guelph provides non-acute and acute services. It also is finalizing plans for redevelopment. When the redevelopment phases of the project are complete the roles of the public hospitals in Guelph will be rationalized as per the recommendations of the Blundell Report earlier in the decade. The General will have a role in acute services while the St. Joseph's will provide non-acute services. Currently the hospitals share management services in activities that will be rationalized to separate sites in the future. For example, there is one director of rehabilitation services between the two sites. The cooperation and collaboration that exists between the hospitals provides a strong platform for future relations.

The Homewood Health Centre provides acute and specialized mental health services. The Homewood HC expressed to the HSRC that due to its private and special status it did not wish to be part of the network. The hospital is the sole provider of acute mental health services and has made arrangements in Guelph to respond to mental health patients presenting at the Emergency Department at the General. The Homewood is physically located across the street from the General. The Homewood is also currently under construction to renovate acute crisis mental health beds.

The HSRC heard from all of the hospitals and the DHC regarding how acute mental health services were organized at the Homewood. The Homewood noted that it had re-allocated resources from inpatient to outpatient. However, most hospitals and other community representatives noted that the access to inpatient acute mental health resources at the Homewood remained a substantial issue.

Lastly, the HSRC was surprised at the lack of effective accountability mechanisms regarding the Homewood Health Centre given that the majority of its funding was derived from the Ministry of Health.

Section C: HSRC Approach to Restructuring in Rural and Northern Communities

The HSRC began its work in rural and northern communities by identifying networks of hospitals. The concept of networks was defined in the Ministry of Health's *Rural and Northern Health Care Framework* policy. Networks were identified as a mechanism for addressing some of the common issues regarding access, quality and affordability in rural and northern communities. The first step for the HSRC was to establish the membership of each network.

In June 1998 the Commission sent letters to all hospitals affected by the Ministry's *Rural and Northern Health Care Framework* suggesting who their network partners should be. The HSRC based its development of the proposed networks on an analysis that considered: where patients live; where patients use local services and where they are referred when they need access to secondary and tertiary services; as well as formal relationships among hospitals. The HSRC also held information sessions for hospitals and district health councils to discuss further the HSRC's proposed process.

A total of 18 networks was proposed (See Appendix 2), each including at least one secondary referral hospital. Members of each network were asked to provide their perspectives on a number of issues. Firstly, with respect to the proposed membership, the HSRC asked:

- *Is the membership appropriate – are the right hospitals included?*
- *If not, what hospitals should be added or included in another network?*
- *How should the DHC contribute to network development?*
- *Should referral centres used by the population served within each network be included?*

Secondly, with respect to organization of the network; that is, its policy- and decision-making capacity, the HSRC asked:

- *How should the network operate?*
- *What governance structure(s) make(s) the most sense?*
- *How will the proposed governance structure contribute to broader service integration that will be considered as part of Stage Two?*

For the most part, there was consensus concerning the proposed membership of the networks. It was also evident that a number of networks were relatively advanced in collaborative activities while others had begun a process to achieve better planning and coordination of service delivery at the local level. A common theme emerging from the initial feedback from many of the networks was a request for more time to develop or enhance their network relationships and the structures by which the members would link with each other.

Overview of Responses

A Planning Committee of the Network #3 hospitals, including Palmerston and District, Palmerston was formed. This committee proposed a Joint Executive Committee to facilitate network relationships. The JEC would coordinate planning and decision-making relative to implementing the policy, principles and benchmarks noted in the Northern and Rural Health Policy. The members wish to include the CCAC. Palmerston was originally assigned to the Huron-Perth (#10) network. However, further examination of the relationships and referral patterns confirmed its membership in this network. Both Wellington and Huron-Perth agreed in writing to the HSRC with its inclusion in Network.

Membership

The major issues identified regarding network membership included:

- Inclusion of Homewood and St. Joseph's is necessary to improve access to acute, non-acute and specialized mental health services for the people of the district

Relationships and Linkages

Hospitals were invited to provide feedback on what organizational linkages and decision-making structures should guide the members of the network in their relationship with each other.

The major issues regarding linkages included:

- Access to services in the rural communities was identified as a significant goal with retention of physicians identified as an ongoing issue
- Build on the current relationships between the public hospitals in Guelph as the basis for future planning and implementation locally

Section D: Network Goals, Objectives and Tasks (Terms of Reference)

The HSRC supports the concept of networks of hospitals to ensure that high quality health care is provided in an accessible and affordable manner in rural and northern communities. The network's challenge is to identify a governance structure that will support collective decision-making among the member hospitals in order to achieve restructuring within the areas served.

The responses from networks have been reviewed by the HSRC. In some cases on-site meetings have been held with network representatives. As a result of the feedback received, and reports on the status of activities voluntarily underway, the HSRC has made modifications to its original approach.

The HSRC will confirm the membership of each network and establish its overall goals and terms of reference. The Commission has developed goals and terms of reference taking into consideration the *MoH Rural and Northern Health Care Framework* and the progress that has been achieved voluntarily by some networks. The specific tasks of the networks have been identified but determining how these tasks will be completed will be the responsibility of each network.

The next step is for each network of hospitals to develop more detailed plans that address specific tasks that put the network in place. Therefore the HSRC is requesting that hospitals in each network develop implementation plans that address the type of relationship among the network members. This plan will outline organizational linkages that the members have developed in the short term plus long term structures and time frames that are envisioned. An outline of the progress made to date in implementing the short term and long term structures for the network is requested. The plans will also include strategies to share administrative, support and clinical services where appropriate, and to determine the roles, and scope of programs, of each of the hospitals in the network.

These plans are to be submitted to the Health Services Restructuring Commission no later than September 20, 1999. A template to be used in submitting the plans has been developed and is attached in the appendices. The HSRC will then review the plans in the context of the objectives and tasks to be completed follow-up accordingly. It is recognized that some networks may want the HSRC to review their plans prior to September 20, 1999

The specific goals and tasks for the network are outlined below.

Network Goals

⇒ To improve access to services for the population served by the network
⇒ To enhance the quality of services provided to the local population by the network hospitals
⇒ To optimize planning and decision-making by the network.

These goals can be accomplished by undertaking the following tasks:

Network Tasks (Terms of Reference)

1. To ensure that appropriate organizational processes and structures are in place to facilitate further development of the network (i.e. sizing, siting, sharing, rationalizing services provision). This process is to include sizing and siting of:

   - *Acute Services:*
     - Secondary Referral Hospitals: The Ministry of Health and the secondary referral hospitals will work together to apply the HSRC benchmarks to these hospital(s) and determine the configuration of services, where required, through the MoH Operating Plan process
     - Rural Hospitals: The network will apply the Ministry of Health/Ontario Hospital Association benchmarks for rural hospitals [8]

   - *Non-acute Hospital Services*:
     - **The MoH will work with the networks to apply the HSRC's[9]** benchmarks and to estimate the sizing, siting and reinvestments required for non-acute services

2. To explore mechanisms that will foster greater collaboration and linkages between hospitals in the network with a focus on benefits that can be derived from:

   - Sharing of administrative services,
   - Sharing of support services,
   - Establishing stronger clinical linkages and service clusters. This should include but is not limited to:
     - Developing standardized approaches to assess the quality of service provided (including practice guidelines/clinical protocols),
     - Establishing common methods to improve utilization,
     - Developing common credentialling,
     - Providing peer review among the network's members,
   - Developing a common strategic plan that will guide the development of an operational plan to serve the needs of the network and help guide clinical, operation, and financial decisions.

3. To clarify linkages and expectations between network participants with a focus on ensuring access to services at secondary referral centres.

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8 *Rural and Northern Health: Parameters and Benchmarks* Report of the Joint Committee of the Ministry of Health and the Ontario Hospital Association, July 1998.

9 *Change and Transition* Planning Guidelines and Implementation Strategies for Home Care, Long Term Care, Mental Health, Rehabilitation and Sub-acute Care

4. To identify linkages with regional referral centres and ensure access to tertiary/quaternary services.
5. To develop strategies to address common or shared human resource issues.

6. To develop strategies to address medical staff and other health professional recruitment and retention strategies.

7. To explore mechanisms for shared or common health information systems.

8. To explore opportunities that may exist within the network to:

    - Establish multi-disciplinary group practice work teams within the hospital or other locations in the network[10]
    - Enhance training/educational opportunities for the education of health professionals.
    - Initiate telemedicine/telecommunication initiatives that will support the needs of the network
    - Develop stronger partnerships with other health providers and organizations in the network to provide a better continuum of care (i.e., patient centered approach).

Network Options to Facilitate Decision-Making

It is expected that the proposed goals and tasks for the network can be achieved through a variety of organizational arrangements. A number of options can be considered to promote greater integration and/or linkages and coordination between and among network hospitals. These options range from organizational models that build upon the status quo to a complete change in organizational arrangements. (See Appendix 4).

Some of the key issues that the network should consider when finalizing the linkages among network members and developing plans for implementation include:

1. **Potential for facilitating decision-making relevant to the Network that will lead to:**

    a) improved quality (i.e. critical mass and clinical coherence)
    b) improved access/accessibility (i.e. population need, service requirements, proximity, patient transfer, tertiary specialized programs)
    c) information sharing
    d) improved efficiency/affordability (i.e., clinical or administrative efficiency, restructuring savings support services consolidation, reduced overhead costs/better technology)
    e) better long term planning and evaluation
    f) improved human resource (HR) planning (i.e., allow for network-wide HR planning, recruitment and retention of medical staff)

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10 See Appendix 3 excerpt from *Examples of Excellence in Primary Care*, Ontario College of Family Physicians

g) supporting further (vertical) integration/coordination

2. **Ability to implement the option including consideration of:**

   a) past record of co-operation between/among hospitals (i.e., previous progress in moving restructuring forward)
   b) consistency/compatibility with other advancements achieved to date (i.e., consideration of vertical linkages and/or other partnerships established)
   c) number of sites
   d) degree of consistency with locally-developed solution (vs. imposed solution)
   e) acceptability based on the consistency of mission, values (including denominational) and principles of the parties

3. **Manageability of decision-making process**

4. **Geography/population considerations**

   (i.e., proximity, shared service areas, population characteristics, indicators of health status)

5. **Patient pattern considerations**

Conclusion

Analysis of the particular characteristics of the network and the above factors will enable the network to select organizational structures that will ensure that the goals for accessible, high quality and affordable health care are met.

Section E: HSRC Conclusions

The HSRC confirms that the network membership will include:

- Guelph General
- Homewood Health Centre, Guelph
- Louise Marshall, Mount Forest.
- St. Joseph's Hospital and Home, Guelph
- Groves Memorial, Fergus
- Palmerston and District, Palmerston

The HSRC expects that the Wellington Network, No. 3, will develop and submit a plan to the HSRC by September 20, 1999. This plan will include the following:

1. Proceed with the network activities including St. Joseph's Hospital, Guelph, the Palmerston & District Hospital and the Homewood Health Centre.
2. CCAC should be involved in the network.
3. Prior to the completion of the redevelopment projects in the Guelph Hospitals, incorporate the appropriate number of complex continuing care, sub-acute and local rehabilitation beds consistent with the roles of the hospitals as identified in the Blundell Report
4. The Network should work as a priority toward addressing issues of access to acute mental health beds at the Homewood Health Centre.
5. Develop further linkages with the Hamilton Health Sciences Corporation (HHSC) and the St. Joseph's Hospitals in Hamilton for secondary and tertiary referrals for services not available locally.
6. The network should proceed with planning to address the following:

    - A statement of vision, mission and core values of the network.
    - The configuration of programs across sites and siting of non-acute services using planning guidelines.
    - Strategies for health professional recruitment and retention.
    - Medical human resource planning and recruitment and retention strategies.
    - Coordinated and collaborative strategies for delivery of hospital services across the broad community
    - The clinical linkages (services and referral mechanisms) with secondary referral hospital(s) that have been established.
    - Strategies for consolidation and sharing of administrative and support services across sites.
    - Mechanisms to inform the communities served on all program and service changes.
    - Mechanisms to monitor quality and access.
    - A plan for implementing a common or shared information system.
    - Strategies for the identification of specific issues relating to the practice of medicine in a rural community and a plan to address the identified issues.

- A dispute resolution mechanism that the network will use to resolve potential disagreement between/among network members.
- Strategies for the involvement of the District Health Council(s) and the Community Care Access Centre(s) in network planning activities.

Plus, the report should contain descriptions of the processes developed by the Network for:

- Overall strategic planning for the area served by the network.
- Planning for and siting of new programs and services.
- Planning for linked or shared clinical or administrative information systems to achieve coordination of services and continuity of patient care.

The final plan developed by the network is expected to address the goals and objectives and the Tasks (Terms of Reference) outlined in Section D. The document should be between 20 to 30 pages long and should follow the template guide contained in Appendix 5. The plan will be reviewed in the context of how the network intends to address the task (terms of reference) outlined.

Appendix 1: Network 3 Wellington

Appendix 2

List of Rural and Northern Networks
Health Services Restructuring Commission

Network
Network 1: (Simcoe/Muskoka) South Muskoka Memorial Hospital, BRACEBRIDGE Huntsville District Memorial Hospital, HUNTSVILLE Royal Victoria Hospital, BARRIE Collingwood General and Marine Hospital, COLLINGWOOD Huronia District Hospital, MIDLAND Orillia Soldiers' Memorial Hospital, ORILLIA Penetanguishene General Hospital, PENETANGUISHENE Penetanguishene Mental Health Centre, PENETANGUISHENE
Network 2: (Grey/ Bruce) Grey Bruce Health Services, OWEN SOUND South Bruce Grey Health Centre, KINCARDINE Hanover and District Hospital, HANOVER
Network 3: (Wellington) Groves Memorial, FERGUS Louise Marshall Hospital, MOUNT FOREST Guelph General Hospital, GUELPH St. Joseph's Hospital and Home, GUELPH The Homewood Health Centre, GUELPH Palmerston and District Hospital, PALMERSTON
Network 4: (Haldimand / Hamilton) Haldimand War Memorial, DUNNVILLE West Haldimand General Hospital, HAGERSVILLE Hamilton Health Sciences Corporation, HAMILTON
Network 5: (Thames Valley) St. Thomas-Elgin General Hospital, ST. THOMAS Strathroy Middlesex General Hospital, STRATHROY Woodstock General Hospital, WOODSTOCK Alexandra Hospital, INGERSOLL Tillsonburg District Memorial Hospital, TILLSONBURG Four Counties Health Services, NEWBURY London Health Sciences Centre, LONDON St. Joseph's Health Centre, LONDON

Network
Network 6: (Nipissing / Timiskaming) Englehart and District Hospital, ENGLEHART Mattawa General Hospital, MATTAWA West Nipissing General Hospital, STURGEON FALLS Temiskaming Hospital, NEW LISKEARD North Bay General, NORTH BAY
Network 7a: (West Ottawa Valley) Almonte General Hospital, ALMONTE Arnprior and District Hospital, ARNPRIOR Carleton Place and District Hospital, CARLETON PLACE Queensway-Carleton Hospital, NEPEAN Kemptville and District Hospital, KEMPVILLE Perth and Smith Falls District Hospital, SMITHS FALLS
Network 7b: (East Ottawa Valley) Hawkesbury General Hospital, HAWKESBURY Winchester and District Memorial Hospital, WINCHESTER The Ottawa Hospital, OTTAWA
Network 8: (West Champlain) Deep River District Hospital, DEEP RIVER Renfrew Victoria Hospital, RENFREW St. Francis Memorial, BARRY'S BAY Pembroke General, PEMBROKE
Network 9: (West Algoma) North Algoma Health Organization (Lady Dunn General), WAWA Sault Ste. Marie General Hospital, SAULT STE. MARIE Plummer Memorial Hospital, SAULT STE. MARIE Thessalon Hospital, THESSALON Matthews Memorial, RICHARDS LANDING Hornepayne Community Hospital, HORNEPAYNE

Network
Network 10: (Huron/Perth) Alexandra Marine & General Hospital, GODERICH Clinton Public Hospital, CLINTON Listowel Memorial Hospital, LISTOWEL Seaforth Community Hospital, SEAFORTH South Huron Hospital, EXETER Stratford General Hospital, STRATFORD St. Mary's Memorial Hospital, ST. MARY'S Wingham & District Hospital, WINGHAM
Network 11: (Sudbury Area) St. Joseph's Health Centre, BLIND RIVER Espanola General Hospital, ESPANOLA Manitoulin Health Centre, LITTLE CURRENT St. Joseph's General Hospital, ELLIOT LAKE Sudbury Regional Hospital, SUDBURY West Parry Sound Health Centre, PARRY SOUND
Network 12: (Northwest) Nipigon District Memorial Hospital, NIPIGON Geraldton District Hospital, GERALDTON Manitouwadge General Hospital, MANITOUWADGE Wilson Memorial General Hospital, MARATHON McCausland Hospital, TERRACE BAY Thunder Bay Regional Hospital, THUNDER BAY St. Joseph's Care Group, THUNDER BAY
Network 13: (Northeast) Anson General Hospital, IROQUOIS FALLS Bingham Memorial Hospital, MATHESON Chapleau Health Services, CHAPLEAU Kirkland and District Hospital, KIRKLAND LAKE Lady Minto Hospital, COCHRANE Notre Dame General, HEARST Sensenbrenner Hospital, KAPUSKASING Smooth Rock Falls General, SMOOTH ROCK FALLS Timmins and District Hospital, TIMMINS

Network
Network 14: (Northwest) Thunder Bay Regional Hospital, THUNDER BAY Lake of the Woods District Hospital, KENORA Riverside Health Care Facilities, FORT FRANCES Dryden District General Hospital, DRYDEN Red Lake Margaret Cochenour Memorial Hospital, RED LAKE Sioux Lookout District Health Centre, SIOUX LOOKOUT Sioux Lookout Zone Hospital, SIOUX LOOKOUT Atikokan General Hospital, ATIKOKAN St. Joseph's Care Group, THUNDER BAY
Network 15: (Alliston/Newmarket) Stevenson Memorial Hospital, ALLISTON York County Hospital, NEWMARKET
Network 16: (Cornwall Area) Glengarry Memorial Hospital, ALEXANDRIA Cornwall General Hospital, CORNWALL Hotel Dieu, CORNWALL
Network 17: (Brant / Norfolk) Norfolk General Hospital, SIMCOE Brantford General Hospital, BRANTFORD Willett General Hospital, PARIS
Network 18: (Dufferin / Northwest GTA) Dufferin-Caledon Health Care Corporation, ORANGEVILLE Northwest GTA Hospital Corporation, BRAMPTON

Appendix 3

Examples of Excellence in Primary Medical Care as Provided by the Ontario College of Family Physicians

The HSRC received a brief entitled *Examples of Excellence in Primary Medical Care* from the Ontario College of Family Physicians outlining some primary care models in Ontario. Some examples cited in the brief include:

- Sioux Lookout: Small Community with a Hospital
- Thames Valley: Small Community without a Hospital
- North Muskoka / East Parry Sound: Larger Community with Regional Integration of Services
- Prescott-Russell: Hospital-based model in Rural Eastern Ontario

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Appendix 4

Organizational Models and Definitions

Amalgamation

Working Definition

- Two or more separate hospital corporations joining together and continuing as one corporation in accordance with the provisions of the *Corporations Act* and the *Public Hospitals Act*.

Essential Elements of Hospital Amalgamation

- Results in a corporate entity (permanent structure)
- Must be full compliance with provisions of *Corporations Act* in order to amalgamate
- Must receive approval of Minister of Health, Public Guardian and Trustee and Ministry of Consumer and Corporate Relations
- Can result in one corporation absorbing the other or in the emergence of a merged corporation with new objects, arising out of the amalgamating corporation.

Subsidiary Governance Model

Subsidiary governance is built on models more prevalent in the private sector, but is quite consistent with the legal requirements of the Public Hospitals Act and other applicable Ontario legislation. A public hospital may carry on some of its activities through a subsidiary corporation, whether the subsidiary is incorporated as a non-share capital corporation under the *Corporations Act* (Ontario), under the *Business Corporations Act* (Ontario) (OBCA), the *Canada Business Corporations Act* (CBCA) or under other statutes.

In order for the subsidiary to be organized as a non-share capital corporation the *Corporations Act* provides that the subsidiary must have "objects that are of a patriotic, religious, philanthropic, charitable, educational, agricultural, scientific, artistic, social, professional, fraternal, sporting or athletic nature or that are of any other useful nature."[11] The impetus to create a subsidiary structure must be a compelling policy requirement for separate but related governance.

The subsidiary facility can have its own budget and operations separated from the parent hospital by agreement and bylaws of the parent hospital. It is a basic principle of corporate law that the board of directors of a subsidiary owes fiduciary duties to the subsidiary, and not to the parent corporation which controls the subsidiary. Therefore, the subsidiary boards of directors can represent the interests of the particular community on the subsidiary board. The drawbacks to the creation of subsidiaries, which must be weighed against the benefits, relate to the sharing of the mission, goals and core values of the parent corporation. In program-specific subsidiaries the loyalty to the particular

[11] *Corporations Act*

program may prove to be an impediment to the unity of focus of the parent corporation. In the context of broad amalgamations of various organizations, the creation of subsidiaries may actually perpetuate the lack of a unified vision that the amalgamation was established to address. Such divided loyalties will always result in tensions and will require patient co-operation between the parent and subsidiary boards.

Subsidiaries must have real activities to govern and meaningful decisions to make. Actual decision-making authority must be delegated from the parent corporation to the subsidiary. If their decision-making is restricted to inconsequential aspects of governance, the question of why the subsidiaries were created in the first instance must be addressed.

Standing Committee Model

If policy reasons exist for preserving particular foci respecting local or special interests, then the governance model created must facilitate the continuing focus on these issues. In the case of smaller hospitals or particular services or clinical programs, fears of attrition of resources to other missions or priorities of the corporation or lack of attention to the interests of the particular community or program area are real. To address the particular requirements of these communities or programs there are mechanisms other than the creation of subsidiary corporations that will guarantee these interests a voice at the board of the amalgamated hospital, ensuring their unique service needs are addressed. The "board committee" mechanism is one such option.

Alliance Agreement

Working Definition

- When two or more hospitals agree by contract to combine funding and management, clinical and/or support services in order to enhance quality and improve the delivery of hospital services through consolidation, without creating a corporation.

Essential Elements of an Alliance Agreement

- the purpose and scope of the alliance
- where its principal office will be located
- the term i.e., duration of the agreement
- the amount of any capital contributions to the alliance by each participant
- accounting procedures and financial and other records
- dissolution and liquidation
- dispute resolution mechanisms
- management of the alliance, including who has decision-making authority and the duties of each participant

Joint (Executive) Committees (JEC)

Working Definition

- An overarching body comprising representatives of the governing boards of two or more participating hospitals, that has authority to make decisions relating to the operations of the participating hospitals in order to facilitate integration and linkages among hospitals, the services they provide, the programs they operate and their clinical, professional and administrative personnel.

Essential Elements of JEC

- Participating hospitals continue to exist as autonomous entities, subject to delegation of certain authority to JEC's
- Explicit delegation of decision-making authority related to specific issues by the governing boards of the JEC
- Relationship should be created by way of written agreement/contract and ideally should set out by-laws or protocols with respect to conduct of affairs and operations of JEC, including accountability and reporting requirements with respect to governing boards.

Contract (Agreement)

Working Definition

- [Except when referring to an Alliance Agreement] the term contract should be used to refer to a written, legally enforceable document setting out the nature of the [integrated] relationship between two or more hospitals, including the contractual rights and duties of each party and any remedies and penalties for breach of such duties.

Essential Elements of a Contract/Agreement

- Meet legal test for valid contract e.g., offer, acceptance, consideration, consensus
- Set out exact nature of contractual rights and duties of each party as well as remedies and penalties for breach thereof

Management/Admin Contract

- A contract between two or more hospitals, setting out the contractual rights and duties of each party relating to shared or integrated administrative and/or management personnel and/or services, including, without limitation, the CEO, the management team, information technology and professional personnel and/or services.

Support Services Contract

- A contract between two or more hospitals, setting out the contractual rights and duties of each party relating to shared or integrated support personnel and/or services, including, without limitation, security, purchasing, housekeeping, food services and laundry personnel and/or services, but excluding laboratory services.

Clinical Services Contract

- A contract between two or more hospitals, setting out the contractual rights and duties of each party relating to shared or integrated clinical personnel and/or services, including, without limitation, medical, dental, nursing, psychology, social work, pharmacy, occupational therapy and physiotherapy personnel and/or services.

APPENDIX 5

RURAL/NORTHERN HOSPITAL RESTRUCTURING
REPORT TO THE HEALTH SERVICES RESTRUCTURING COMMISSION
September 20, 1999

1. One report shall be submitted on behalf of the network. The report shall conform to the following:

- The title page shall include the full legal name of the organization, and the name, full address, postal code, telephone and fax number of the person with whom the Commission may correspond;
- A summary not exceeding 350 words shall be included, setting-out the significant points that are addressed in the submission;
- The following specifications shall be observed:
  - *Font: 12 point*
  - *Page size: 8-1/2" X 11", single-sided*
  - *Margins: 1 inch on all sides*
  - *Line spacing: 1-1/2*
  - *Maximum pages: 30 including summary and appendices; plus title page*
  - *No of copies: 5 to be submitted*
  - *The report should be signed by the Board Chairs of the Network hospitals.*

The body of the report should contain five sections.

Section I: Introduction

This section will include a statement of the vision, mission and core values of the network..

Section II: Organizational arrangements/linkages of the network

Section II should describe the organizational arrangements and linkages between the hospitals. The intent is to determine how the network has addressed the tasks outlined in Section D of this report. The key tasks to be discussed in this section pertain to the following:

- *To ensure that appropriate organizational processes and structures are in place to facilitate further development of the networks.*
- *To clarify linkages and expectations between network participants with a focus on ensuring access to services at secondary referral centres.*

In some networks, there may be transitional or short-term arrangements made between hospitals as an interim measure. Therefore, this section should include the transitional or short term linkages and organizational processes that might be required as well as the longer term arrangements and processes that are planned.

Part A: Transitional/Short-Term Linkage Arrangements.

- Linkages and organizational processes among the members and with the secondary referral centre.
- Strategies to ensure access to tertiary/quaternary services.

Part B: Longer Term Arrangements/Linkages (timeframe)

- Linkages and organizational processes among the members and with the secondary referral centre.
- Strategies to ensure access to tertiary/quaternary services.

Section III: Sizing and Siting of Services

Section III should describe the sizing and siting of acute and non-acute services within the network. Section D of this report provides specific guidelines. The report needs to identify what decisions have been made by the network, in conjunction with the Ministry of Health, regarding the sizing and siting of all services. The MoH will apply the HSRC acute care benchmarks to the secondary hospital (where appropriate) and will work with the networks to apply the non-acute benchmarks.

The network will use the Ministry of Health (MoH) and Ontario Hospital Association (OHA) *Parameters and Benchmarks* to complete the sizing of acute services in the in rural hospitals.

The final siting of services can be summarized by completing the number of beds allocated to each hospital in each category, in the following table format:

Summary of Network Bed Allocation

Hospital	Acute	Subacute	Complex Continuing Care	Rehabilitation	Mental Health	TOTAL

Section IV: Progress and Plans Regarding Achievement of Tasks/Terms of Reference

This section should provide details on the Network progress-to-date and the long range plans of the Network regarding the points outlined below:

- Sharing of administration services.
- Sharing of support services.
- Establishing stronger clinical linkages & service clusters within the network.
- Developing standardized approaches to assess the quality of service provided among network members.
- Establishing common methods to monitor/improve utilization of hospital services.
- Developing common credentialling systems (including practice guidelines/clinical protocols).
- Developing mechanisms for peer review among the network's members.
- Development of a common strategic plan that will guide the development of a common operating plan.
- Strategies to address common or shared human resource issues.
- Strategies to address medical staff and other health professional recruitment and retention issues.
- Strategies to identify specific issues related to the practice of medicine in a rural community and a plan to address the identified issues.
- Mechanisms for shared or common health information systems.
- Mechanisms for the identification of new program needs and siting of services to meet the needs.
- Mechanisms to inform the community on program and service changes within the network.
- Strategies for the involvement of the District Health Council(s) and Community Care Access Centre(s) in network planning activities.
- A dispute resolution mechanism.

Opportunities that may exist by using the hospital infrastructure as a mechanism for:

- The establishment of multi-disciplinary group practice work teams within the network.
- Enhancement of training/ educational opportunities for the education of health professionals.
- Teleconferencing or distance education initiatives.
- Partnerships with other health providers and organizations in the network to provide a better continuum of care.

Section V: Specific Network Issues

Section V should describe particular issues that are a concern of the network. This may include, for example, issues related to delivery of services to specific populations; the role of specialty hospitals located within the network; plans for dealing with particular health issues specific to the network population; issues related to geography or distance, etc.